HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antiparasitics - Topical

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a documented history of therapeutic failure, a contraindication to, or intolerance of the preferred products (e.g., piperonyl butoxide/pyrethrum shampoo, permethrin cream rinse 1 percent, Natroba topical suspension, permethrin 5 percent cream, Sklice lotion)?

☐ Yes ☐ No

Q2. Is this a request for lindane shampoo?

☐ Yes ☐ No

Q3. Does the patient weigh 50 kilograms or greater?

☐ Yes ☐ No

Q4. Does the patient take any medications that may reduce the seizure threshold (such as but not limited to: meperidine, cyclosporine, theophylline)?

☐ Yes ☐ No

Q5. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

v2025